III. Treatment of Wounds of the Intestine. By Dr. CHAPUT. Ch. condemns, in a most unqualified manner, the expectant treatment of wounds of the intestine, the mortality of which is from 50 to 60 per cent. The hitherto unpromising results obtained by laparotomy are attributed to either a late application of this procedure, the overlooking of perforations or imperfect suturing. In dogs, invariable success followed his efforts, in the repair of wounds artificially produced, by means of laparotomy.

Senn's method of ascertaining whether or not perforation exists by forcing hydrogen gas into the bowel through the anus and identifying the presence of the latter at the abdominal wound by lighting it as it escapes, is rejected by Ch., on the ground that considerable force is necessary to drive the gas beyond the ileo cœcal valve, and when this is accomplished the sudden influx of the gas from the distended colon will convert incomplete perforations into perforating wounds, or separate commencing adhesions. Exploratory laparotomy is preferred to Senn's diagnostic method, each portion of intestine being carefully and systematically gone over, from the ileo-cœcal valve to the duodenum; the stomach and larger intestine being examined last. Each perforation is grasped by means of clamp forceps as soon as it is discovered; suturing of all the perforations is done afterwards.

In cleaning the peritoneum dry sterilized sponges are used, and all antiseptic fluids dispensed with.

In case of excessive hemorrhage, Ch. follows Senn's proposal and makes digital compression of the aorta until the bleeding points are identified and secured.

In closing intestinal wounds amounting to more than one-fourth of the circumference of the bowel Ch. recommends his methods of transplantation of intestine ("greffe intestinal"). This consists essentially in closing the perforation with a healthy loop of intestine. For this purpose a point in the intestinal track is selected fifteen to twenty centimetre above or below the perforation, bringing this in contact with the wounded intestine and securing the two together by a double row of sutures. In case of double perforation a double transplantation may be employed and resection of the injured bowel be avoided. Should two perforations occur close beside each other it is

better to form one large opening by removing the portion lying between the openings, and transplant as before.

The method of transplantation here suggested is based upon an experimental study in eighteen animals. In all eighteen cases the transplantation was successful.—*Gaz. des hôpitaux*, 1892, No. 138.

IV. Tuberculous Strictures of the Bowels and Their Treatment. By Dr. F. Konig. K. observed and operated upon five cases of tuberculous stricture of the bowel, a disease, the clinical appearances of which are so typical as to present a picture with striking characteristics. The patients' ages varied from twenty to forty years, only exceeding this in one case. In this a woman of fifty-two years. The patient had suffered from gastric symptoms which developed slowly; pallor and emaciation appearing simultaneously. Later there occurred attacks of colicky pains pointing without doubt to stricture of the bowel. With varying frequency, several times a day and again less often, the abdomen became the site of painful distention; loops of bowel with serpentine movements and a splashing noise is noticed upon succussion. The attack terminates by the contents of the bowel being forced through the stricture; in the meantime a characteristic noise as if a fluid is pressed out of a syringe becomes audible upon auscultation. Immediately the abdomen flattens and the patient is relieved for a time. Operation discloses conditions corresponding to the picture of the disease. The stricture of the bowel originating from the tuberculous ulcer of the bowel is found with considerable lessening of the lumen from cicatrization. Above this point the bowel is greatly dilated with hypertrophy of the muscular coat; below, the bowel is contracted or rather atrophied. Typical circular resection of bowel for the removal of the obstruction is indicated as well as removal of the affected mesenteric glands. This procedure is justified by the fact that, as a rule, the tuberculous affection of the bowel in these cases is circumscribed and localized and, as shown by the cicatrization, has an intrinsic tendency to recovery. The diagnosis of a stricture due to tuberculosis will sometimes be suggested by other existing tuberculous affections. Two out of K's five patients died soon after the operation; one from asthenia and one